ADHS-DBHS BEHAVIORAL HEALTH CLIENT COVER SHEET

Name_____ DOB_____ Client CIS ID#_____
Address _____ Client SS#_____
City_____ State_____ Zip _____ AHCCCS ID#_____
Phone_____ E-Mail_____ AHCCCS Health Plan_____
Gender: □ Male □ Female Primary/Preferred Language_____

Special Needs:

Interpreter	□ No	□ Yes, specify language_____
Mobility Assistance	□ No	□ Yes, identify assistance needed_____
Visual Impairment Assistance	□ No	□ Yes, identify assistance needed_____
Hearing Impairment Assistance	□ No	□ Yes, identify assistance needed_____
Need Childcare Arrangements	□ No	□ Yes, identify need_____

Due to cognitive impairments requires special assistance to participate in the assessment/service planning process. □ No □ Yes

Key Contacts:

PCP/Physician: _____ Phone_____ Fax_____
PCP/Physician Address: _____
Legal Guardian: _____ Phone_____
Custody: □ Sole □ Joint □ Ward of Court (DES Legal Guardian)_____
Parent(s)/Step Parent(s) _____ Phone_____
_____ Phone_____
_____ Phone_____
Emergency Contact: _____ Phone_____
Address_____

Other Key Contacts (e.g., school, probation/parole officer, other involved agencies (CPS, DDD), neighbors, grandparents):

Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____
Name and Relationship to Person _____
Phone_____ Fax_____

Insurance Coverage: □ Medicare □ Private (self-pay) □ TriCare □ Blue Cross □ HMO □ Other □ None

Insurance Co_____ Insurance ID #:_____ Policy No:_____
(Attach copy of insurance card)

Individual Completing Form and Title:_____ Date_____

ADHS-DBHS BEHAVIORAL HEALTH ASSESSMENT AND SERVICE PLAN CHECKLIST

Name_____ Date of Birth_____ Client CIS ID#_____
Accompanying Family Member/Significant Other (note relationship to person):_____
_____

Part A: Behavioral Health and Medical History Questionnaire (may be completed by person/family prior to first interview) **Pages 2 - 5**

☐ Completed by person prior to initial interview
☐ Completed during interview by assessor

Part B: Core Assessment (must be completed at this initial interview) **Pages 6 - 15**

- Presenting Concerns
- Behavioral Health and Medical History
- Criminal Justice
- Substance Related Disorders
- Abuse/Sexual Risk Behavior
- Risk Assessment
- Mental Status Exam
- Clinical Formulation and Diagnoses
- Next Steps/Interim Service Plan

Part C: Additional Addenda (may be completed at subsequent appointment) **Pages 16 - 26**

Indicate below, which of the addenda you as the assessor have completed on the person during this interview

Yes	To Be Done Later	Not Applicable	Name of Addendum
☐	☐	-------	Living Environment (For all persons)
☐	☐	-------	Family/Community Involvement (For all persons)
☐	☐	-------	Educational/Vocational Training (For all persons)
☐	☐	☐	Employment (For persons 16 years and older and others if pertinent)
☐	☐	☐	Problem Gambling Screen (For persons 16 years and older)
☐	☐	☐	Developmental History (For all children or for adults who have developmental disabilities)
☐	☐	☐	Criminal Justice (For persons with legal involvement)
☐	☐	☐	Seriously Mentally Ill Determination (For persons who request SMI determination or have SMI qualifying diagnosis and GAF score 50 or lower)
☐	-------	☐	Child Protective Services (used for 24 hour urgent response for children removed by Child Protective Services)
☐	-------	☐	Special Suicide Risk Assessment (For all persons in crisis situations)

Part D: Behavioral Health Service Plan (may be completed at subsequent appointment) **Pages 27 - 28**

☐ Completed at initial interview ☐ Will be completed later

Part E: Annual Behavioral Health Update and Review Summary **Pages 29 - 30**

_____ _____ _____
Assessor's Name (print) / Signature Credentials/Position Date

_____ _____ _____
Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

_____
Agency

PART A: BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date of Birth_____ Client CIS ID#_____
(to be filled in by provider)

Accompanying Family Member/Significant Other (note relationship to person):_____
_____

1. Are you currently taking any **medications** (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)? □ No, go to question 2.
□ Yes, answer questions 1(a) - 1(e) below.

1(a) Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below:

_____ _____
Name of Medication Reason for Taking Medication

_____ _____
Name of Medication Reason for Taking Medication

_____ _____
Name of Medication Reason for Taking Medication

_____ _____
Name of Medication Reason for Taking Medication

_____ _____
Name of Medication Reason for Taking Medication

1(b) Have any of your medications been changed in the last month? ☐ No ☐ Yes**,** list the medications that have changed and explain why they were changed._____
_____
_____

1(c) How long will your current supply of medications last? (How urgent is your need to obtain medications?)_____
_____

1(d) Describe any side effects that you find troublesome from any of the medications you are currently taking._____
_____
_____

1(e) Do you have any abnormal/unusual muscle movements? □ No □ Yes, how is it being treated?_____
_____

2. Are you **allergic** to any medications? □ No □ Yes, which ones?_____

3. Do you have any other **allergies**? □ No □ Yes, describe them._____

4. When was the last time you saw your **primary care physician/dentist** and what was the purpose of that visit?_____
_____

5. Do you have any history of **head injury** with concussion or loss of consciousness? □ No □ Yes, describe._____
_____

6. Are you currently **pregnant**? □ No □ Yes □ Unsure

7. Are there any **medical problems** that you are currently receiving treatment for? □ No, go to question 8.
□ Yes, answer 7(a) and 7(b) below.

7(a) Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem	Type of Treatment Receiving
_____	_____
_____	_____
_____	_____

7(b) Does your current medical condition(s) create problems in how you deal with life, including pain? ☐ No ☐ Yes, if yes explain._____
_____
_____
_____

8. Have you recently experienced any of the following?

Ear/Nose/Throat:
Severe dry mouth □ No □ Yes, when _____
Ear infections □ No □ Yes, when _____
Persistent sore throat □ No □ Yes, when _____

Respiratory System:
Respiratory infections □ No □ Yes, when _____
Persistent cough □ No □ Yes, when _____
Shortness of breath □ No □ Yes, when _____

Cardiovascular:
Chest pain □ No □ Yes, where _____
Swelling in legs, ankles, feet □ No □ Yes, where _____

Gastro-intestinal:
Persistent nausea / vomiting □ No □ Yes, when _____
Self-induced vomiting □ No □ Yes, when _____
Frequent or prolonged diarrhea / constipation □ No □ Yes, when _____
Excessive use of laxatives □ No □ Yes, when _____
Weight loss / gain □ No □ Yes, when _____
Blood in stools □ No □ Yes, when _____
Abdominal pain □ No □ Yes, when _____

Genitourinary:
Urinary discomfort □ No □ Yes, when _____
Frequent urination □ No □ Yes
Blood in urine □ No □ Yes, when _____

Musculoskeletal:
Joint pain □ No □ Yes, when _____
Back pain □ No □ Yes, when _____

Neurological:

Facial or muscle twitching/jerking □ No □ Yes, when _____
Seizures □ No □ Yes, when _____
Passing out □ No □ Yes, when _____
Dizziness □ No □ Yes, when _____
Headaches □ No □ Yes, when _____

Infectious Diseases:

Sexually Transmitted Diseases □ No □ Yes, when _____ what_____

Other:

Inappropriate defecation (bowel elimination) □ No □ Yes, when _____
Inappropriate bed wetting □ No □ Yes, when _____
Dry skin □ No □ Yes, when _____
Hair loss □ No □ Yes, when _____
Unusual sweats or chills □ No □ Yes, when _____
Surgeries □ No □ Yes, when _____what _____
Problem with sleeping □ No □ Yes, indicate more or less sleep _____

Other conditions not listed above (signs and symptoms)

_____
_____
_____
_____

9. Do you **use tobacco**? □ No □ Yes, how much per day?_____ How long have you been using tobacco?_____ (yrs/mths)

10. Do you consume **caffeine**? □ No □ Yes, how many cups/cans do you drink per day?_____

11. In total, how much **fluid** do you drink, i.e., how many cups/cans of total fluids do you drink per day? _____

12. Have you **ever received out-patient** (office-based) **services**, been **hospitalized** or received services in a **residential facility** for **behavioral health concerns**?
□ No, go to question 13.
□ Yes, answer questions 12(a) – 12(c).

12(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

_____	_____
Type of Treatment	When and Where Received
_____	_____
Type of Treatment	When and Where Received
_____	_____
Type of Treatment	When and Where Received
_____	_____
Type of Treatment	When and Where Received

12(b) What current or prior treatment/services, including medication, do you think have been the <u>most helpful</u> in addressing your behavioral health symptoms? Explain _____
_____

12(c) What current or prior treatment/services, including medication, do you think have been the <u>least helpful</u> in addressing your behavioral health symptoms? Explain _____

13. Describe any current or past **behavioral health issues** (including substance abuse) in your **family.** (*For purposes of this question family may include birth family, adopted family, foster family and/or family person is or has lived with.*)_____

If the person seeking behavioral health services was provided assistance in filling out this questionnaire, please provide the name,date of completion and telephone number of the individual providing this assistance.

Name (please print)_____ Date_____ Phone_____

PART B: CORE ASSESSMENT

PRESENTING CONCERNS

1. What are you seeking help for today? _____
_____
_____
_____
_____
_____

2. How long have these issues been a concern? How often are these an issue for you?_____
_____
_____
_____
_____
_____

3. How do these concerns affect your daily living? How have they impacted your family/significant others?_____
_____
_____
_____
_____
_____

4. What has been done so far to address these concerns? What seems to help? What makes them worse?_____
_____
_____
_____

5. How will you know if things are better/improving?_____
_____
_____
_____
_____

6. What type of resources or supports do you have available to help address these concerns?_____
_____
_____
_____

7. What type of assistance do you or others feel you need? (If others, specify who and relationship.)_____
_____
_____
_____

8. Describe your preferences about behavioral health services relating to your culture, faith, spiritual beliefs or any other factors (e.g., provider gender preference, utilization of alternative medicine or traditional healer, sexual orientation)?_____
_____
_____
_____

BEHAVIORAL HEALTH AND MEDICAL HISTORY

The Behavioral Health and Medical History Questionnaire should be reviewed by assessor with the person/family or filled out if not completed ahead of time by person/family.

CRIMINAL JUSTICE

1. Are you currently or have you in the past been involved with the legal system (e.g., probation, parole, jail, pending charges, court-ordered treatment)? ☐ No ☐ Yes, if yes, explain._____
_____

If the response was yes, the Criminal Justice Addendum should be completed but this can occur at a follow-up appointment.

SUBSTANCE RELATED DISORDERS

A. Screening for Substance Use

1. Based on a review of available documentation, the assessor should answer the following:

a. Referral source indicates the person has a substance related problem? ☐ No ☐ Yes
b. Person's medical history indicates past medical condition, hospitalization or emergency room treatment for a substance related medical issue (includes detoxification in the past 2 years)? ☐ No ☐ Yes
c. Medication history suggests person is using prescription medicines in inappropriate combinations or doses? ☐ No ☐ Yes
d. Person's behavioral health history indicates an episode of substance related treatment in the past 2 years? ☐ No ☐ Yes

2. If none of the answers above are yes then depending on the situation ask:

a. Do you now or have you ever had a problem with alcohol or drugs? ☐ No ☐ Yes
b. Is a spouse/significant other or family member concerned about your use of alcohol or drugs? ☐ No ☐ Yes
c. If a parent/legal guardian/spouse/significant other is present ask:
c (i) Do you feel the person (and/or his/her friends in the case of a child) is currently using alcohol or drugs? ☐ No ☐ Yes
c (ii) Has the person (and/or his/her friends in the case of a child) gotten into trouble for such use? ☐ No ☐ Yes

ONLY complete Sections B and C below, if the response to any of the questions in Section A above is yes.

B. Current and Past Substance Use

1. What are your drinking habits? (e.g., How much, how often and what do you drink? Do you ever drink more than you meant to or feel preoccupied with wanting to drink? Have you neglected some of your usual responsibilities in order to drink? Have you felt you wanted or needed to cut down on drinking or tried to stop but could not? Have you given up or reduced important activities in order to drink?)_____
_____
_____

2. Have you ever taken any drugs other than alcohol to get high, sleep better, feel better or lose weight? (e.g., How much, how often, how used and reasons for use? Do you ever use more than you meant to or feel preoccupied with buying drugs or using drugs? Have you neglected some of your usual responsibilities in order to use? Have you felt you wanted or needed to cut down or tried to stop but could not? Have you given up or reduced important activities in order to buy or use drugs?)_____
_____
_____
_____

SUBSTANCE RELATED DISORDERS (con't)

3. Complete the table below for each substance the person has used in the past 12 months. However, in the far right column indicate primary (P) or secondary (S) for current substance use (i.e., used in the past 30 days or 30 days before being placed in a controlled environment).

SUBSTANCE USE **(CIRCLE IF USED IN PAST 12 MONTHS)**	**Freq.** (use code below)	**Route** (use code below)	**Age First Used**	**When Last Used**	**Current Use (past 30 days)** Primary (P) or Secondary (S)
(0201) Alcohol					
(0401) Marijuana					
Stimulants **(1001)** Methamphetamine **(0302)** Cocaine/crack **(1201)** Other (e.g., Ritalin, amphetamine)					
Opiates/Narcotics **(0501)** Heroin **(0706)** Other (e.g., codeine, hydrocodone, oxycodone, oxycontin, propoxyphene, non-prescription methadone)					
Depressants **(1308)** Benzodiazepines (e.g., Valium, Klonopin, Ativan, Xanax, Halcion) **(1605)** Other sedatives, tranquilizers hypnotics (e.g., Soma, Benadryl, barbiturates)					
(0902) Hallucinogens: LSD, PCP, MDMA, shrooms, ecstasy, ketamine, psilocybin, etc.					
(1703) Inhalants: glue, paint, gasoline, other solvents/ aerosols, etc.					
(2002) Other Drugs: non-narcotic analgesics, GHB, other/unclassified and other medications used in excess of prescription [e.g., Prozac, Haldol, Robitussum]. Specify type:_____					

Codes for Table Above:

Frequency of Use/Abuse

1 No use in past 30 days
2 1-3 times in past 30 days
3 1-2 times per week
4 3-6 times per week
5 Daily/multiple times per day

Route of Administration

1 Oral
2 Smoked
3 Inhaled
4 Injected
5 Other (specify in table)

SUBSTANCE RELATED DISORDERS (con't)

C. Relapse and Recovery Environment

1. Continued Use/Relapse Potential

1(a) Assess and describe the level of structure, supervision, safety and medication needed by the person in order to avoid/limit continued substance use or a relapse event (e.g., Will you drink/use when you leave here today? Have you ever abstained on your own before? When did that occur? How did you do that?)_____
_____
_____

1(b) Based on this assessment, indicate below which statement best describes the person:

- ☐ **Can Independently Abstain**
- ☐ **Need for Encouragement**: Person needs encouragement not to use; has fair self-management and relapse coping skills.
- ☐ **Need for Supervision**: Impaired recognition or understanding of relapse issues, but able to self-manage with prompting.
- ☐ **Need for Structure / Supervision**: Little recognition or understanding of relapse issues; no/poor skills to cope with and interrupt addiction problems or to avoid/limit relapse; no imminent danger.
- ☐ **Safety Risk**: Person is unable to prevent relapse; continued use places person or others in imminent danger.

2. Recovery Environment

2(a) Assess and describe the level of support for recovery in the person's home, community and immediate surroundings, and the level of services and supports necessary for the person to cope with a negative environment (e.g., How does the person currently cope with his/her environment? Are these strategies effective? Is the person willing to learn more effective coping skills? Does the person need an alternative environment?) _____
_____
_____
_____

2(b) Based on this assessment, indicate below which statement best describes the person:

- ☐ Environment is supportive of recovery.
- ☐ Environment contains triggers that exposes person to continued use (job, friends, school, neighborhood); able to cope most of the time.
- ☐ Person is living in an unsupportive environment; difficult/unable to cope even with clinical support.
- ☐ Person is living in an environment that would hinder recovery (shelter, non-therapeutic residential setting, homeless).
- ☐ Person is living with active users or in an abusive situation.

Responses in this section combined with information from other areas of the core assessment should be used to make a differential diagnosis when completing the Clinical Formulation and Diagnoses Section.

ABUSE/SEXUAL RISK BEHAVIOR

1. Do you feel safe in your current living situation? outside of your home? ☐ Yes ☐ No, if no briefly explain. _____
_____

2. Are you currently or have you ever been hurt, harmed, touched inappropriately, or abused by someone in any way? (Consider any physical, sexual, or emotional abuse) ☐ No ☐ Yes, if yes, explain including times when abuse occurred, action taken (e.g., notification of authorities, resulting steps taken)._____
_____
_____

ABUSE/SEXUAL RISK BEHAVIOR (con't)

3. Is any member of your household/family currently being or has ever been harmed, abused, neglected, or victimized? (Consider any physical, sexual, or emotional abuse.) ☐ No ☐ Yes, if yes explain (including any Child Protective Services (CPS) or Adult Protective Services involvement)._____

4. Do you engage in any sexual behaviors that you are concerned about, or that have raised concerns in your family or community (sexual acting out, inappropriate touching, exposure)? ☐ No ☐ Yes, if yes, explain._____

ONLY complete the questions below, if the response is no to question 1 or yes to questions 2, 3 or 4.

5. How do you think the issues identified above affect you now? _____

6. Do you believe that any of the issues that you have indicated above should be a focus of your treatment at this time?
☐ No ☐ Yes, if yes, explain._____

7. Based on the person's responses, does the assessor feel there is an immediate safety risk for the person or others in the household or members of the community? ☐ No ☐ Yes, if yes, explain._____

Duty to Report: If you as the assessor believe that the person is a victim of abuse, neglect or exploitation, you may have an obligation under A.R.S. 13-3620 or 46-454 to make a report to a peace officer or child/adult protective services. If duty to report is warranted explain the action to be taken._____

RISK ASSESSMENT

1. Have you ever thought about harming yourself or someone else? ☐ No ☐ Yes, if yes, did you have a plan and when was the last time you thought about harming yourself or someone else?_____

2. Have you ever harmed/injured yourself or someone else intentionally? ☐ No ☐ Yes, if yes, did you have a plan and when was the last time you harmed yourself or someone else?_____

ONLY complete the rest of the risk assessment questions, if the response to question 1 or 2 is yes (note: complete questions 3 if the risk is harm to self and/or question 4 if the risk is harm to others).

3. Risk of Harm to Self

3(a) Indicate which of the following suicide (harm to self) risk factors apply to the person:

Prior suicide attempt	☐ No ☐ Yes	Behavioral cues (e.g., isolation, impulsivity, withdrawn, angry, agitated)	☐ No ☐ Yes
Repeated attempts; increasing severity	☐ No ☐ Yes	Symptoms of psychosis (especially command hallucinations)	☐ No ☐ Yes
Stated plan with intent	☐ No ☐ Yes	Family history of suicide	☐ No ☐ Yes
Access to means (e.g., weapon)	☐ No ☐ Yes	History of suicide in friend	☐ No ☐ Yes
Substance use (current/past)	☐ No ☐ Yes	Terminal physical illness	☐ No ☐ Yes
Other self-abusing behavior	☐ No ☐ Yes	Current stressors	☐ No ☐ Yes
Recent losses / lack of support	☐ No ☐ Yes		

RISK ASSESSMENT (con't)

3(b) Provide more detailed explanation for any of the above risk factors that apply._____
_____
_____

4. Risk of Harm to Others

4(a) Indicate which of the following homicide risk factors apply to the person:

Prior acts of violence	☐ No ☐ Yes	Substance use (current/past)	☐ No ☐ Yes
Fire setting	☐ No ☐ Yes	Symptoms of psychosis (especially command hallucinations)	☐ No ☐ Yes
Angry mood / agitation	☐ No ☐ Yes	Physically abused as child	☐ No ☐ Yes
Arrests for violence	☐ No ☐ Yes	Current stressors	☐ No ☐ Yes
Prior hospitalizations for dangerousness	☐ No ☐ Yes		
Access to means (e.g., weapon)	☐ No ☐ Yes		

4(b) Provide more detailed explanation for any of the above risk factors that apply_____
_____
_____

5. Does the person demonstrate symptoms that suggest a risk for DTs, withdrawal, seizures, overdose or toxic use that may require immediate interventions? ☐ No ☐ Yes, if yes explain_____
_____

6. In terms of other potential risk factors, does the person appear:

Malnourished	☐ No ☐ Yes, if yes explain_____
Dehydrated	☐ No ☐ Yes, if yes explain_____
Dirty/malodorous	☐ No ☐ Yes, if yes explain_____
At-risk of exposure to the elements	☐ No ☐ Yes, if yes explain_____

7. Considering the responses to the above risk factors in combination with all the other information you know about the person (e.g., gender, age, diagnosis, balancing factors – resiliency and supports), would you rate the level of risk for this person as:
☐ Low Risk ☐ Medium Risk ☐ High Risk ? Please explain your rating._____
_____

Duty to Protect / Duty to Warn (Tarasoff and A.R.S. 36-517.02). This applies when a practitioner is confronted with a person who makes a credible threat against another identified individual. When this occurs, the practitioner must take reasonable steps to prevent harm per A.R.S. 36-517.02. If duty to protect/duty to warn warranted in this case, explain the action to be taken and factors affecting the decision._____
_____

MENTAL STATUS EXAM

While prompts are provided below, the assessor should make sure to describe his/her observations and impressions of the person for each question below.

1. Describe the **person's interaction** with you and others in attendance; include general observations about the person's appearance, behavior and social interaction:_____
_____

2. **Motor Activity** (e.g., orderly, calm, agitated, restless, hypoactive, tics, mannerisms, tremors, convulsions, ataxia, akathisia):_____
_____

Name:_____

MENTAL STATUS EXAM (con't)

3. **Mood** (*Sustained emotional state*, e.g., relaxed, happy, anxious, angry, depressed, hopeless, hopeful, apathetic, euphoric, euthymic, elated, irritable, fearful, silly): _____
_____

4. **Affect** (*Outward expression of person's current feeling state,* e.g., broad range, appropriate to thought content, inappropriate to thought content, labile, flat, blunted):_____
_____

5. **Self-concept** (e.g., self-assured, realistic, low self-esteem, inflated self-esteem):_____
_____

6. **Speech** (e.g., mute, talkative, articulate, normally responsive, rapid, slow, slurred, stuttering, loud, whispered, mumbled, spontaneous, stilted, aphasic, repetitive):_____
_____

7. **Thought Process** (e.g., logical, relevant, coherent, goal directed, illogical, incoherent, circumstantial, rambling, pressured, flight of ideas, loose associations, tangential, grossly disorganized, blocking, neologisms, clanging, confused, perplexed, confabulating):_____

8. **Thought Content** (e.g., optimistic, grandiose, delusions, preoccupations, hallucinations, ideas of references, obsessions/compulsions, phobias, poverty of content, suicidal or homicidal ideation, prejudices/biases, hypochondriacal, depressive):
_____

9. **Intellectual Functions:**

9(a) **Sensorium** (e.g., orientation – person, place, time, situation):_____
_____

9(b) **Memory** (e.g., recent, remote, retention and recall (3 object memory, recall: immediate / 5 minutes; digit span memory):_____
_____

9(c) **Intellectual Capacity** (e.g., general information (current events, geographical facts, current/past presidents), calculations (serial 3's or 7's), abstraction and comprehension (comparison and differences, proverb interpretations)):_____
_____

9(d) **Estimated Intelligence** (e.g., below average, average, above average, unable to determine):_____
_____

10. **Judgment and Impulse Control** (e.g., good, partial, limited, poor, none):_____
_____

11. **Insight** (e.g., good, fair, poor, none):_____
_____

Name:_____

CLINICAL FORMULATION AND DIAGNOSES

A. Clinical Formulation/Case Summary: The assessor should ensure this succinct paragraph:

- Provides a descriptive picture of the person through summarization of pertinent data for person's medical/ behavioral health history and mental status findings.
- Summarizes how bio-psycho-social, environmental, cultural, personality and family factors and unique mental/social functioning have influenced person's history and current status.
- Identifies strengths and needs of person and his/her family.
- Prioritizes needs to be addressed; allowing assessor and person/family to readily understand what needs to be done next.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

B. Diagnostic Summary:

1. **Axis I**

DSM-IV TR Code	DSM-IV Diagnosis	DSM-IV TR Code	DSM-IV Diagnosis
DSM-IV TR Code	DSM-IV Diagnosis	DSM-IV TR Code	DSM-IV Diagnosis
DSM-IV TR Code	DSM-IV Diagnosis		

2. **Axis II**

DSM-IV TR Code	DSM-IV Diagnosis	DSM-IV TR Code	DSM-IV Diagnosis

3. **Axis III - Medical Conditions:** Identify the person's specific medical conditions and check the disease categories below that apply. _____
_____

- **A.** ☐ **Infectious and Parasitic Diseases** (001-139): abscesses, infections, tuberculosis, HIV/AIDS, pneumonia, blood infections
- **B.** ☐ **Neoplasms** (140-239): cancer
- **C.** ☐ **Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders** (240-279): diabetes, thyroid or hormonal disorders, iron or vitamin deficiencies, salt imbalances, immune deficiencies
- **D.** ☐ **Diseases of the Blood and Blood-Forming Organs** (280-289): hemophilia, anemia
- **E.** ☐ **Diseases of the Nervous System and Sense Organs** (320-389): blindness, deafness, loss of sensation, Parkinson's disease, multiple sclerosis, Lou Gehrig's disease (ALS), Huntington's disease (chorea), Alzheimer's disease, strokes with loss of function
- **F.** ☐ **Diseases of the Circulatory System** (390-459): heart attacks, strokes, heart failure, aneurysm, loss of circulation in extremities

Name:_____

CLINICAL FORMULATION AND DIAGNOSES (con't)

3. **Axis III** (continued)

- **G.** ☐ **Diseases of the Respiratory System** (460-519): asthma, chronic obstructive lung disease, emphysema
- **H.** ☐ **Diseases of the Digestive System** (520-579): stomach disorders, ulcers, esophageal reflux (GERD), Crohn's disease, colitis, constipation, hemorrhoids, liver disease, pancreatic disease
- **I.** ☐ **Diseases of the Genitourinary System** (580-629): urinary incontinence, bladder problems, menstrual disorders, ovarian, cervical or uterine disorders, prostate disorders, kidney (renal) disorders
- **J.** ☐ **Complications of Pregnancy, Childbirth, and the Puerperium** (630-676): peri-natal disorders
- **K.** ☐ **Diseases of the Skin and Subcutaneous Tissue** (680-709)
- **L.** ☐ **Diseases of the Musculoskeletal System and Connective Tissue** (710-739): orthopedic disorders, fractures/dislocations/deformities
- **M.** ☐ **Congenital Anomalies** (740-759): genetic disorders, birth deformities
- **N.** ☐ **Certain Conditions Originating in the Perinatal Period** (760-779): failure to thrive, colic, feeding problems
- **O.** ☐ **Symptoms, Signs, and Ill-Defined Conditions** (780-799)
- **P.** ☐ **Injury and Poisoning** (800-999): traumatic injuries, ingestions of poisonous/toxic substances

4. **Axis IV - Psychosocial or Environmental Stressors**

Problems with / related to:

☐ Primary Support Group	☐ Educational Problems	☐ Occupational Problems
☐ Marital Problems	☐ Housing Problems	☐ Interaction with Legal System
☐ Access to Health Care Services	☐ Family Problems	☐ Substance Use in Home

☐Other_____

Significant recent losses:

☐ Death	☐ Injury	☐ Medical/Surgical
☐ Job	☐ Divorce/Separation	☐ Accident/Injury
☐ Child removed from home	☐ Violent Acts Against Person/Family	

☐Other_____

5. **Axis V - Global Assessment of Functioning (CGAS/GAF) Score** (specific score not a range): _____**

Scale	Children's Global Assessment Scale (CGAS) Children (4-16 years of age)	Global Assessment of Functioning (GAF) (All Others)
100-91	Superior Functioning	Superior Functioning
90-81	Good Functioning in All Areas	No or Minimal Symptoms
80-71	No More Than Slight Impairment in Functioning	Slight Impairment if Symptoms are Present
70-61	Some Difficulty in A Single Area, But Generally Functioning Pretty Well	Mild Symptoms
60-51	Variable Functioning with Sporadic Difficulties or Symptoms in Several but Not All Social Areas	Moderate Symptoms
50-41	Moderate Degree of Interference in Functioning in Most Social Areas or Severe Impairment of Functioning in One Area	Impaired Reality Testing/Major Symptoms in Several Areas
40-31	Major Impairment in Functioning in Several Areas and Unable to Function in One of These Areas	Some Impaired Reality Testing / Major Impairment in Several Areas
30-21	Unable to Function in Almost All Areas	Delusional / Hallucinations / Inability to Function in Almost All Areas
20-11	Needs Considerable Supervision	Danger to Self/Others/Gross Impairment in Functioning/Hygiene
10-1	Needs Constant Supervision	Persistent Danger/Serious Impairments

*****If the person has a GAF score that is 50 or lower and a SMI qualifying diagnosis, the assessor must complete the SMI Determination Addendum.***

Name:_____

NEXT STEPS/INTERIM SERVICE PLAN

1. Identify specific people who may be supportive and helpful and who should be invited to be part of the person's ongoing Team, including phone numbers and action to be taken:_____
_____
_____

2. Identify any additional documentation (e.g., medical records, IEP, probation report), which needs to be collected to assist in the ongoing assessment and service planning including the individuals and/or agencies and action to be taken to obtain this information:
_____
_____

3. Identify who the person and/or family/legal guardian/significant other should contact if the person needs immediate assistance before the next appointment:_____
_____

4. **Interim Service Plan.** Based on the person's presenting issues, your impressions and the preferences of the person and his/her family/legal guardian/significant other, describe in the Interim Service Plan on the next page recommended next steps (e.g., formation of Team, response to immediate risks and needs of the person, further assessment). Additionally, this Interim Service Plan should include:

- Any immediate next steps to be taken by the person and/or family/legal guardian/significant others.
- Referral to the person's primary care physician, if *physical health problems* have been identified.
- Additional considerations for urgent response for children removed by Child Protective Services (see shaded box below).

Assessors may also add a goal statement, if appropriate.

For urgent response for **children removed by Child Protective Services**, the assessor must include as part of the recommended next steps/interim service plan, identification of:

1. Actions needed to be taken immediately to mitigate the effects of the removal itself;
2. Supports and services the child's caregivers may need to meet the child's needs; and
3. A plan to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral health needs within at least the next 23 days (or sooner if indicated).

The assessor may also provide any input he/she has regarding the types and amount/frequency of contact (e.g., visits, phone calls, e-mail), the child should have with parents, siblings, relatives and other individuals important to the child.

Name:_____

INTERIM SERVICE PLAN

Description of Next Steps (Action) to Be Taken	**Who Will Be Responsible to Ensure Action Occurs**	**Where Action/Step Will Take Place (e.g., provider)**	**When Action/ Step Will Take Place**

_____ _____
Person/Guardian Signature Date

_____ _____ _____
Assessor's Name (print) / Signature Credentials/Position Date

_____ _____ _____
Behavioral Health Professional Reviewer Name (print) / Signature Credentials/Position Date

_____
Agency

Note: The assessor should make sure to provide the person/guardian with a copy of the interim service plan. The CPS specialist, however, should receive a copy of the entire next steps/ interim service plan section.

Name:_____

PART C: ADDITIONAL ADDENDA

LIVING ENVIRONMENT

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

1. Briefly describe your living environment. Where do you live? Do you like it? Who do you live with? How do you spend a typical day? (e.g., What is the flow of your day like? Do you have specific daily activities - what are they, which ones do you enjoy? Do you know each day what you will be doing that day? Do you do things at the same time each day? Are you with others during the day? What makes for a good day?) _____
_____
_____
_____
_____
_____
_____
_____

2. Have you recently experienced any significant change in your living environment/situation (e.g., removal from family, divorce, adoption, school suspension, family death, auto accident, loss of job/income)? ☐ No ☐ Yes If yes, how have you dealt with this issue?_____
_____
_____

3. If appropriate, ask: How long have you been in this country? How is life different here?_____
_____
_____

If indicated by results of Mental Status Exam and/or responses to Risk Assessment questions in the Core Assessment ask:

4. How well are you able to complete activities of daily living (e.g., bathing, eating, dressing, household management, homework, chores)? Explain any difficulties, including the type of assistance required._____
_____
_____
_____
_____

FAMILY/COMMUNITY INVOLVEMENT

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

1. Describe the relationships you are involved in and how you feel about these people (e.g. family, friends, significant others, staff person if in out-of-home placement, community relationships). In general, how do you get along with others?_____
_____
_____
_____
_____
_____

2. Which people are you most comfortable confiding in? Do you think these people would be supportive and helpful to you at this time? ☐ No ☐ Yes, who are these people and how do they help? (contact information is optional)_____
_____
_____

FAMILY/COMMUNITY INVOLVEMENT (con't)

3. What are the things that make you feel good about yourself and help make your life meaningful (including interests, strengths, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, your culture/community, work, school, etc.)?_____
_____
_____
_____

4. What do others consider to be your strengths (including interests, talents, skills and abilities, knowledge/education, friends, family, values, religion/spirituality, your culture/community, work, school, etc.)?_____
_____
_____
_____
_____

5. Is there anything about you, your family or your culture that would help us understand you, and how people respond to you? How does your culture influence you or people around you? Please describe._____
_____
_____
_____

EDUCATIONAL/VOCATIONAL TRAINING

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

1. Are you currently involved in an educational or vocational training program? ☐ Yes ☐ No

1(a) If <u>yes</u>, describe how you are doing in school/training. (Do you like it? What about it do you like? Do you participate in any activities?) _____
_____
_____

1(b) If <u>no</u>, are you interested in becoming involved in an educational or vocational training program? ☐ No ☐ Yes, if yes please explain your reasons and describe your interests._____
_____

1(c) If <u>no and of school age</u>, what situations have lead to you not being in school?_____
_____

2. Describe how school/training impacts or has impacted your life (both positive and negative aspects)._____
_____
_____
_____

3. What is or has been your prior experience in school/training?_____
_____
_____

4. Have you ever been told you have special educational needs? ☐ No ☐ Yes, what was done about it (testing, special evaluation, special classes, development of an IEP/504, alternative school, change of teacher)._____
_____
_____

EMPLOYMENT
(Persons 16 and older or others if pertinent)

If addendum completed at follow-up appointment, assessor should sign _____and date_____

1. Are you currently working (full, part-time or volunteer)? ☐ Yes ☐ No

1(a) If yes, describe your current job, (e.g., type of work, work environment, length of employment, attitude toward work) and how the work affects your life (e.g., family, leisure time, health, relationships)? _____
_____
_____
_____
_____
_____

1(b) If no, when was the last time you worked (i.e., date) and what prompted the change (e.g., reasons you left that job)? Are you interested in finding employment (describe interests)?_____
_____
_____
_____

2. Describe your work and/or military history. How do you feel about it? How has it has impacted your life?_____
_____
_____
_____

3. Describe strengths or barriers that have influenced your ability to work._____
_____
_____

4. Are there any supports or resources you need in order to get a job and/or keep your current job?_____
_____
_____

PROBLEM GAMBLING SCREEN
(Persons 16 and older)

If addendum completed at follow-up appointment, assessor should sign _____and date_____

1. Have you ever felt the need to bet more and more money? ☐ Yes ☐ No

2. Have you ever had to lie to people important to you about how much you gambled? ☐ Yes ☐ No

If the responses to question 1 or 2 is yes, and if the person is not eligible for Title XIX/XXI services, please refer the person to the Arizona Office of Problem Gambling Toll Free Helpline: 1-877-921-4004 or if available, to a problem gambling program provided by your agency.

DEVELOPMENTAL HISTORY

(All children and adults with developmental disabilities)

If addendum completed at follow-up appointment, assessor should sign _____and date_____

1. During pregnancy did this person's mother:

Receive health care?	☐ No ☐ Yes, if yes specify: _____
Drink alcohol?	☐ No ☐ Yes, if yes specify: _____
Use tobacco?	☐ No ☐ Yes, if yes specify: _____
Use any illicit drugs?	☐ No ☐ Yes, if yes specify: _____
Use any medications?	☐ No ☐ Yes, if yes specify: _____
Have any medical or emotional problems?	☐ No ☐ Yes, if yes specify: _____
Experience complications during labor/delivery?	☐ No ☐ Yes, if yes specify: _____
Give birth prematurely?	☐ No ☐ Yes, if yes specify: _____

2. Timing of Developmental Events

(a) By 0-1 year of age, had this person:

Sat up?	☐ Yes ☐ No, if no explain_____
Crawled?	☐ Yes ☐ No, if no explain_____

(b) By 1-3 years of age, had this person:

Walked alone?	☐ Yes ☐ No, if no explain_____
Used first words?	☐ Yes ☐ No, if no explain_____
Fed self with spoon?	☐ Yes ☐ No, if no explain_____

(c) By 3-5 years of age, had this person:

Been toilet trained?	☐ Yes ☐ No, if no explain_____
Used first sentences?	☐ Yes ☐ No, if no explain_____
Learned to ride a tricycle?	☐ Yes ☐ No, if no explain_____

3. Other Developmental Issues: Indicate below if the person ever experienced any of the following:

(a) Could not gain weight	☐ No ☐ Yes, age began _____ and if resolved when _____
(b) Wet the bed or soiled his/her clothes	☐ No ☐ Yes, age began _____ and if resolved when_____
(c) Had difficulty with coordination	☐ No ☐ Yes, age began _____ and if resolved when _____
(d) Had difficulty with speech	☐ No ☐ Yes, age began _____ and if resolved when _____
(e) Had unusual sensitivity to touch	☐ No ☐ Yes, age began _____ and if resolved when _____
(f) Had difficulty with social skills	☐ No ☐ Yes, age began _____ and if resolved when _____

(g) Was evaluated for taking too much time to develop certain skills (e.g., communicating, reading, spelling) ☐ No ☐ Yes, if yes specify: _____

_____

(h) Was evaluated for speech and language delays? ☐ No ☐ Yes, if yes specify: _____

_____

4. Please provide any additional information that might be helpful regarding any other issues or significant events that should be considered._____

_____

_____

_____

5. Has or is the person receiving services from the Department of Economic Security, Division of Developmental Disabilities (DDD)? ☐ No ☐ Yes, describe. (Also make sure to indicate if available the worker's name and contact information on the cover sheet)_____

_____

CRIMINAL JUSTICE
(Persons with legal involvement)

If addendum completed at follow-up appointment, assessor should sign _____and date_____

1. Recent Criminal Justice History

1(a). **Criminal Justice Involvement**	**Current (last 30 days)**	**Past Six Months**
Legal Issues (e.g., pending charges, court dates)	☐ No ☐ Yes	☐ No ☐ Yes
Probation	☐ No ☐ Yes	☐ No ☐ Yes
Parole	☐ No ☐ Yes	☐ No ☐ Yes
Court-Ordered Treatment	☐ No ☐ Yes	☐ No ☐ Yes
Arrests		☐ No ☐ Yes, if yes how many?_____

1(b) Provide additional information about any of the items marked "yes" above._____
_____
_____
_____

2. Does this person have a Probation/Parole Officer? ☐ No ☐ Yes, indicate type and conditions of parole/probation:
_____

If "yes" make sure the Officer's name and phone number is recorded on the Cover Sheet.

3. Describe any other past significant offenses** for which you have been arrested/charged and/or adjudicated (including type of offense, date of offense, legal action taken, resolution, current status) and what impact these events have had on your life. _____
_____
_____
_____
_____
_____

4. As a result of involvement with the legal system, have there been any positive aspects/benefits that have resulted for you and/or your family? If so, please describe:_____
_____
_____
_____
_____

**Offenses might include but not be limited to any of the following: alcohol/tobacco, arson, assault/battery, auto theft, burglary, child molestation, criminal damage, cruelty to animals, curfew violation, domestic violence, drugs (possession, distribution), endangerment/weapons, DUI/DWI, forgery, fraud, manslaughter/murder, probation/parole violation, prostitution, robbery, sexual assault/rape, shoplifting, theft, trespassing, truancy.

SERIOUSLY MENTALLY ILL (SMI) DETERMINATION

(Persons who request SMI determination or have SMI qualifying diagnosis and GAF score 50 or lower)

I. Preliminary SMI Eligibility Determination Recommendation

Based upon my direct behavioral health assessment of this person, I _____ _____

Assessor's Name (print)/ Signature Credentials/Position

make the following preliminary SMI eligibility recommendation.

1. Preliminary Recommendation of Qualifying SMI Diagnosis: *(Circle the person's principal diagnosis (es) supported by available information.)*

Psychotic disorders (295.10, 295.20, 295.30, 295.60, 295.70, 297.1, 295.90, 298.9); **Bipolar disorders** (296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89); **Obsessive-compulsive disorder** (300.3); **Major Depression** (296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36); **Other Mood Disorders** (296.90, 301.13, 311, 300.4**); Anxiety disorders** (300.00, 300.01, 300.02, 300.14, 300.21, 300.22, 309.81); **Personality disorders** (301.0, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, 301.9)

1(a) The above noted diagnosis(es) is/are suggested based upon the following signs and symptoms of the mental disorder(s): (Provide descriptions of both positive (confirming) findings and negative ("rule-out") findings for other diagnoses that were considered.) _____
_____
_____
_____
_____

1(b) Based on the assessment and other available information, the person's current GAF score was determined to be _____

2. Preliminary Recommendation of Functional Criteria: As a result of the above diagnosis, the person exhibits any item listed under 2 (a), (b) and/or (c) for most of the past twelve months **or** for most of the past six months with an expected continued duration of at least six months:

☐ 2(a) **Inability to live in an independent or family setting with out supervision (Self Care/Basic Needs)** - The person's capacity to live independently or in a family setting, including the capacity to provide or arrange for needs such as food, clothing, shelter and medical care.

- ☐ Neglect or disruption of ability to attend to basic needs.
- ☐ Needs assistance in caring for self.
- ☐ Unable to care for self in safe or sanitary manner.
- ☐ Housing, food and clothing, must be provided or arranged for by others.
- ☐ Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care.
- ☐ Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions.
- ☐ Refuses treatment for life threatening illnesses because of behavioral health disorder.

☐ 2(b) **A risk of serious harm to self or others (Social/Legal and/or Feeling/Affect/Mood)** - The extent and ease with which the person is able to maintain conduct within the limits prescribed by law, rules and social expectations, and/or the extent to which the person's emotional life is well modulated or out of control.

- ☐ Seriously disruptive to family and/or community.
- ☐ Pervasively or imminently dangerous to others' bodily safety.
- ☐ Regularly engages in assaultive behavior.
- ☐ Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior.
- ☐ Persistently neglectful or abusive towards others in the person's care.
- ☐ Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan.
- ☐ Affective disruption causes significant damage to the person's education, livelihood, career, or personal relationships.

SMI DETERMINATION (con't)

☐ 2(c) **Dysfunction in Role Performance** - Person's capacity to perform the present major role function in society --- school, work, parenting or other developmentally appropriate responsibility.

- ☐ Frequently disruptive or in trouble at work or at school.
- ☐ Frequently terminated from work or suspended/expelled from school.
- ☐ Major disruption of role functioning.
- ☐ Requires structured or supervised work or school setting.
- ☐ Performance significantly below expectation for cognitive/developmental level.
- ☐ Unable to work, attend school, or meet other developmentally appropriate responsibilities.

3. Risk of Deterioration

☐ The person does not currently meet any one of the above functional criteria 2(a) through 2(c) but may be expected to deteriorate to such a level without treatment.

- ☐ A qualifying diagnosis with probable chronic, relapsing and remitting course.
- ☐ Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.).
- ☐ Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.).
- ☐ **Other** (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

If any of the above boxes are checked,, document reason:_____
_____
_____

4. The above noted Functional Criteria ratings are suggested based upon the following information regarding this person's functioning: (Provide a description of both the positive (confirming) findings and negative ("rule-out") findings of the functioning of this person) _____
_____
_____
_____

_____ _____ _____
Assessor's Name (print) / Signature Credentials/Position Date

II. Final SMI Eligibility Determination

☐ **SMI** - All of the available information supports the conclusion that the above person has a qualifying diagnosis (1) AND either meets one or more functional criteria (2) OR is at risk of deterioration (3) and therefore meets ADHS/DBHS clinical criteria for SMI.

☐ **Not SMI** - The above person does not meet ADHS/DBHS clinical criteria for SMI.

Clinical rationale for final determination: _____
_____
_____
_____
_____
_____
_____

_____ _____ _____
Reviewer Name (print) / Signature Credentials/Position Date

CHILD PROTECTIVE SERVICES
(For 24 hour urgent response for children removed by Child Protective Services)

The questions contained in this addendum are primarily intended to be responded to by the Child Protective Service specialist involved with the child's case. In addition to this addendum, the assessor should complete the Behavioral Health Client Sheet, the Client Demographic Information Sheet and the following sections in the Core Assessment: Risk Assessment, Mental Status Exam, Diagnostic Summary and the Next Steps/Interim Service Plan. The remainder of the Core Assessment should only be completed at this time only if the child's clinical condition/circumstances allow. The assessor should make sure that the Child Protective Service Specialist's name and phone number is recorded on the Cover Sheet.

1. What are the reasons for the removal of the child from the parent /guardian? Are there other siblings in the family and/or living in the same home? Are other siblings victims of abuse and has CPS removed them? Explain._____
_____
_____
_____

2. Has the child had prior involvement with Child Protective Services? ☐ No ☐ Yes, if yes explain. _____
_____
_____
_____

3. What is the child's perception of his/her parents, siblings, and/or family? What is the child's perception of his/her relationship with his/her parents/siblings/family? What are the child's feelings, sense of attachment, trust, security, love and affection toward his/her parents/guardian?_____
_____
_____

4. Was the child or the family receiving behavioral health services prior to the removal from the parent/guardian's home?
☐ No ☐ Yes, if yes explain. _____
_____
_____

For Questions 5 through 9 the assessor should check below those statements which best describe the child based on the assessor's observations and discussion with the Child Protective Service specialist at the time of the interview.

5. General presentation for children 0-3 years of age
- ☐ Crying
- ☐ Clingy
- ☐ Hard to soothe
- ☐ Regressed
- ☐ Tantruming
- ☐ Disengaged
- ☐ Head-banging

6. General presentation for children 4 years of age or older:
- ☐ Listless, withdrawn
- ☐ Disinterested
- ☐ Anxious
- ☐ Fearful
- ☐ Angry
- ☐ Labile
- ☐ Fussy
- ☐ Shocked
- ☐ Sad
- ☐ Hearing voices
- ☐ Suicidal
- ☐ Violent, homicidal

7. Understanding of removal process:
- ☐ Confused
- ☐ Self Blaming
- ☐ Realistic
- ☐ Distorted
- ☐ Age appropriate
- ☐ No understanding
- ☐ No age appropriate understanding

8. Sense of future
- ☐ Hopeful
- ☐ Realistic
- ☐ Unrealistically Optimistic
- ☐ Pessimistic
- ☐ Empowered
- ☐ Planning own destiny
- ☐ Unable to perceive a future
- ☐ No age appropriate understanding

CHILD PROTECTIVE SERVICES (con't)

9. Understanding of placement options
- ☐ Good
- ☐ Poor
- ☐ No age appropriate understanding

10. Describe the child's way of coping with the removal (e.g., blaming others, in denial, developing physical symptoms, regressing in behavior, accepting, etc.). _____

11. What do you or the child feel will be helpful in soothing the child, providing immediate comfort or mitigating the trauma of the removal? (e.g., special foods, transitional object, parental visits, maintenance in current school, contact with friends, church attendance.)_____

12. Describe any requirements of the child welfare plan that may affect the child's behavioral health service plan (e.g., limited parental or sibling involvement.)._____

13. Assessor should provide summary of observations:_____

SPECIAL SUICIDE RISK ASSESSMENT
(For all persons in crisis situations)

The Special Suicide Risk Assessment was designed for use in crisis situations, when it is not feasible to complete the core assessment. In an emergency, the person's immediate clinical needs must be initially addressed. To ensure the person's safety, any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk.

Person's Name: _____ **ID#:** _____**DOB:**_____
Address: _____ **Date:** _____
Phone: _____ **Contact Type:** Telephone ☐ Walk-in ☐ **Time:**_____
Location of Person (if other than above): _____
Gender: M ☐ F ☐ **Primary/Preferred Language:** _____**Crisis Plan?** N ☐ Y ☐ **Date:** _____

1. **PRESENTING PROBLEM OR REQUEST FOR ASSISTANCE**:	
2. **TRIAGE**: a. Are you able to keep yourself safe until this assessment is completed? ☐ Yes ☐ No b. Are you in possession of a gun or weapon or do you have easy access to a gun or weapon? ☐ Yes ☐ No c. Have you felt like hurting yourself ☐ Yes ☐ No or anyone else? ☐ Yes – *Refer to Core Risk Assessment for Harm to Others* ☐ No d. Have you already hurt yourself or anyone else? ☐ Yes ☐ No	
Note: *If person answers "Yes" to 2d above and the level of risk is determined to be severe at this point, and a mobile crisis response team has been dispatched to continue the assessment, it is not necessary to complete the remainder of this form.*	
3. **IDEATIONS**: (Describe any thoughts of dying or killing oneself in detail, using person's own words. Include circumstances that trigger suicidal thoughts.) Ideation is: Fleeting ☐ Periodic ☐ Constant ☐ Increasing in: Severity ☐ Urgency ☐ Frequency ☐	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No thoughts←→Obsessive thoughts)
4. **PLAN**: (How would person carry out ideations? Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Unclear ←→ Detailed & specific)
5. **MEANS**: (Instruments to be used; access to instruments. Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No access ←→ Continuous access)
6. **LETHALITY**: (Dangerousness of plan. Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Minimal risk←→Certainty of death)
7. **INTENT**: (Reports desire and intent to act on suicidal thoughts. Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No desire/denial←→Desire to complete plan)
8. **HISTORY**: (Suicide and self-harming behaviors, self and family; Attempts: number, when, method, lethality, rescues, etc. Begin with past three months.) What has prevented person from acting on suicidal thoughts in the past?	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No history←→Multiple life threatening acts or severe attempts)
9. **SUBSTANCE ABUSE/USE**: (History of use/abuse, access to substances, including family member substance abuse) Is person currently using? If so, list substance(s), amount, and when taken.	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (None ←→ Heavy use/dependence)
10. **ACUTE LIFE STRESSORS**: (Situation/recent changes with family, relationship, job, school, health, divorce, marriage, grief, losses, financial, residential instability, bullying, etc.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Few stressors←→Many stressors)

PART C: ADDITIONAL ADDENDA **Name:**_____

11. **DEPRESSION/AGITATION**: (Affect, anxiety, restlessness, symptoms of depression)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Normal affect←→Severe depression)
12. **HOPELESSNESS**: (Future orientation)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Can see future←→Unable to see)
13. **PSYCHOTIC PROCESSES**: (History/symptoms of psychosis, delusions, auditory/visual hallucinations. Include dates, diagnoses, meds.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No history←→Severe delusions)
14. **MEDICAL FACTORS**: (History/current medical conditions including chronic and severe pain, terminal illness, etc.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No history←→Multiple symptoms)
15. **BEHAVIORAL CUES**: (Isolation, impulsivity, hostility, rage, etc.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Minimal ←→ Extreme)
16. **COPING SKILLS**: (Helplessness, negation of self and others)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Good coping skills←→Poor coping)
17. **SUPPORT SYSTEM**: (Family, friends, co-workers, roommates, spiritual affiliation, civic, school, etc. Define relationship(s) and details using person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Supportive contacts←→No support)
18. **OTHER FACTORS**: (<u>OPTIONAL.</u> If previously mentioned, describe any recent lifestyle changes, sexual identity/orientation issues, involvement w/justice system, communication skills, other diagnoses.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Small significance←→Severe impact)
19. **CULTURAL CONSIDERATIONS**: (<u>OPTIONAL.</u> If mentioned, describe person's attitude towards suicide—acceptance, ambivalence, rejection, etc; cultural views on death and suicide; specific concerns)	
20. **OVERALL RISK LEVEL**:	Low ☐ Med ☐ High ☐
21. **REASONING**: (Identify risk factors and factors offsetting risks)	
RISKS:	**OFFSETS**:
22. **ACTION TAKEN**: (Client signed Crisis Plan? Y ☐ N ☐ Interim Service Plan Completed? Y ☐ N ☐ Include details of appointments/referrals made)	

Clinician/BHP: _____ _____ _____
Print Name *Signature and Credentials* *Date*

Clinical Liaison: _____ _____ _____
Print Name *Signature and Credentials* *Date*

Supervisor: _____ _____ _____
Print Name *Signature and Credentials* *Date*

PART D: BEHAVIORAL HEALTH SERVICE PLAN

Name: _____ CIS Client ID# _____ Program:_____ Today's Date: _____
Individuals at Service Planning Meeting: _____
_____

RECOVERY GOAL/PERSON-FAMILY VISION:

PERSON'S STRENGTHS:

Review Date (Objective Target Date): _____

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	**Current Measure**	**INTERVENTIONS to MEET OBJECTIVES**		**Desired Measure**	**Achieved Measure** (at target date)	**Measure Met** (Y/N)
		Specific Services and Frequency	**Strengths Used**			
1						
2						
3						

DISCHARGE PLAN (add discharge date if known):

☐ Yes, I am in agreement with the types and levels of services included in my service plan.

☐ No, I disagree with the types and/or levels of some or all of the services included in my service plan. By checking this box, I will receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/ or levels of services that I have requested. *

Person / Guardian _____ Date:_____

Clinical Liaison_____ Date:_____ Other_____ Date:_____

BH Prof. Rev._____ Date:_____ Other_____ Date:_____

*If no is checked, a Notice of Action (PM Form 5.1.1) must be provided to the person if the disagreement concerns a Title XIX/XXI covered service. If the disagreement pertains to a Non-Title XIX/XXI covered service and the person has been determined to have a serious mental illness, the person must be given the Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness (PM Form 5.5.1).

BEHAVIORAL HEALTH SERVICE PLAN REVIEW OF PROGRESS

Name:_____

I. Review of Progress

Provide a summary below of the progress the person has made toward meeting the objectives identified on the service plan. In addition, indicate any adjustments that are being made to the service plan objectives and/or measures, including the justification and any additional needs or strengths that have been identified.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

II. Current Diagnostic Summary

Describe and explain any changes in diagnoses and functioning of person: _____
_____
_____
_____
_____

III. Team Members Present at Plan Review Meeting (CFT Planning):_____

_____
_____

IV. Date of Next Plan Review (CFT Planning) Meeting:_____

V. Clinical Liaison (responsible for reviewing clinical record)

_____	_____	_____
Clinical Liaison's Name (print) / Signature	Credentials/Position	Date
_____	_____	_____
Behavioral Health Professional Reviewer Name (print) / Signature	Credentials/Position	Date

PART E: ANNUAL BEHAVIORAL HEALTH UPDATE AND REVIEW SUMMARY

Name _____ Date of Birth _____ Client CIS ID# _____
Accompanying Family Member/Significant Other (Note relationship to person):_____
_____
Date of Current Assessment/Review _____ Date of Initial Assessment/Last Review_____

I. SERVICES AND TREATMENT SUMMARY During the past year consider the following: medications and target symptoms response to treatment; significant medication side effects/adverse drug reactions, AIMS tests; significant medical conditions and response to treatment; significant laboratory findings; cultural preferences/considerations for service provision; other therapeutic interventions, services or supports provided and response to treatment (e.g., What helped? What did not help or made condition worse?); overall functioning over time since the last assessment; overall progress (or lack of); significant events/trauma since the last assessment/review, including any hospitalizations, arrests/incarcerations.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

II. CURRENT STATUS

1. List all currently prescribed medications and dosages, including medications prescribed for other physical/medical conditions:

Medication:	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. List all other therapeutic interventions/services/supports currently utilized:

_____
_____
_____

3. Describe person's current overall functioning and progress in reaching treatment objectives: Consider functioning related to the following areas as appropriate - substance abuse/dependence; living environment; activities of daily living; educational/vocational training; employment; interpersonal relationships; social/cultural; legal/criminal justice involvement.

_____
_____
_____
_____

4. Describe any significant long-term chronic risk factors such as harm to self or others; drug withdrawal or overdose/toxic use; nutrition or exposure to the elements; exploitation, abuse, or neglect.

_____
_____
_____

PART E: ANNUAL BEHAVIORAL HEALTH UPDATE AND REVIEW SUMMARY

III. CURRENT DIAGNOSTIC SUMMARY

1. **Axis I**. DSM-IV TR Code | Diagnosis | Justification for diagnoses (es)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

1. **Axis Ii** . DSM-IV TR Code | Diagnosis | Justification for diagnosis (es)

_____ _____ _____
_____ _____ _____

3. **Axis III**. Identify the person's specific medical conditions and check below the disease categories that apply.

_____

☐ Infectious and Parasitic Diseases (001-139)
☐ Neoplasms (140-239)
☐ Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
☐ Diseases of the Blood and Blood-Forming Organs (280-289)
☐ Diseases of the Nervous System and Sense Organs (320-389)
☐ Diseases of the Circulatory System (390-459)
☐ **Diseases of the Respiratory System (460-519)**
☐ Diseases of the Digestive System (520-579)
☐ Diseases of the Genitourinary System (580-629)
☐ Complications of Pregnancy, Childbirth, Puerperium (630-676)
☐ **Diseases of the Skin and Subcutaneous Tissue (680-709)**
☐ Diseases of the Musculoskeletal System and Connective Tissue (710-739)
☐ Congenital Anomalies (740-759):
☐ Certain Conditions Originating in Perinatal Period (760-779)
☐ Symptoms, Signs, and Ill-Defined Conditions (780-799)
☐ Injury and Poisoning (800-999)

4. **Axis IV**. (Psychosocial or Environmental Stressors) _____

5. **Axis V**. (GAF or CGAS score)_____

IV. RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT

1. List prior goals that have not been achieved that still need to remain a focus of services/treatment:_____
_____

2. List any new goals for the service plan:_____
_____

3. List other ongoing needs or concerns that need to be addressed, including coordination of care with PCP:_____
_____

4. Identify any areas in the assessment that need to be reassessed due to significant changes, e.g., person's condition, living environment, support structure:_____
_____

_____ _____ _____
Clinical Liaison's Name (print) / Signature | Credentials/Position | Date

_____ _____ _____
Behavioral Health Professional Reviewer Name (print) / Signature | Credentials/Position | Date

_____
Agency

REMINDER: All demographic data reported to ADHS/DBHS must be reviewed during annual update. Based on this review:

- At a minimum the following demographic/clinical data fields must be reported to ADHS/DBHS regardless of whether they have changed since the last data submittal: Diagnostic related information (Axis I, II, V and GAF/CGAS), behavioral health category, employment and educational status, primary residence, number of arrests since the last data update and primary and secondary substance use; and/or
- All other demographic information that has changed (e.g., other agency involvement, income for non-Title XIX/XXI eligibles).